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VALUE IN HEALTH

Decision Makers' Needs as Capacities to Benefit

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This particular ISPOR Task Force set out to determine the needs of decision makers in relation to pharmacoeconomic/health economic studies, in particular economic evaluations. Most health economists have been brought up to believe that there is little place for the concept of "need" unless it is defined as "capacity to benefit." You cannot need something if you do not have the capacity to benefit from having it. So if decision makers need economic evaluations then it will be because they have the capacity to benefit from them. But that is the problem, which the Task Force has delicately uncovered (again)—it is far from clear that most decision makers do currently have the capacity to benefit from economic evaluations.

The temptation is for decision makers to turn this into a problem of communication and translation and health economists to go along with this diagnosis in masochistic fashion. But this is a fallacy. Physicists can certainly attempt to communicate the "gist" of relativity theory to the nonphysicist, but it can only be the gist, not the theory, or the analysis underlying it. It is not a failure of communication to say that at the end of even the most valiant attempt (e.g., by Stephen Hawking) many of us have only very modest and partial understanding and that black holes are still a "black box." That is our problem, not the physicists. Technical language, too often disparaged as jargon, is usually the necessary reflection and embodiment of the analysis-to-intuition ratio appropriate to the discourse concerned. Its function is not to impose "artificial" barriers between different discourses, or to be "excluding," but the latter is its necessary and unavoidable consequence. (The use of jargon to defend incomes or status is not unknown but it is only because there is a genuine reason for jargon that this ploy can work.)

The difference with health care is that we are not making decisions about space travel. Health economists who sit on bodies such as NICE are often intrigued by the imbalance between the rigor required and displayed in the papers submitted to the committee and the rigor of the ensuing discussion of them. This is not a question of the integrity or effort or values of the people involved in the discussion, but of the simple difference, verging on incompatibility, between the analysis-to-intuition ratio essential to the reports (on clinical or cost-effectiveness) and the analysis-to-intuition ratio possible in any conversational or discursive process. This is true whatever the analytical capacities of the people present, but it is much compounded by the presence of vastly differing levels and types of analytical capacity, all too often glorified as constituting "multidisciplinarity." This is not a critique of the principle of multidisciplinarity in its ideal form, but a sensible skepticism about its actual practice and its almost ubiquitous tendency to degenerate into something approaching nondisciplinarity.

Of course many will prefer this discursive process and enunciate various worries about black box models, especially their opaqueness, and the dangers of "technocratic reductionism." But transparency is in the eye of the beholder and it is well known that we see what we believe, that is, are able to see given our beliefs and capacities, rather than believe what we see. What we can see *through* is determined by the penetrating capacity of our vision. That capacity should be appropriate to the task and this applies to those charged with decision making as well as any other task. For me the great value of the report lies in the fact that it eventually concludes that we must be very careful about defining best/good practice in catering for the needs of decision makers when those (perceived) needs may reflect poor practice in decision making.

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